CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 121 **Date: SEPTEMBER 14, 2005**

CHANGE REQUEST 3952

SUBJECT: Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims

I. SUMMARY OF CHANGES:

- Section 302 (a) (2) (E) (iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sets forth revised conditions for Medicare payment of Power Mobility Devices (PMDs).

- This section of the MMA sets forth that payment for motorized or power wheelchairs may not be made unless a physician (as defined in section 1861(r)(1) of the Act), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has conducted a face-to-face examination of the beneficiary and written a prescription for the PMD.

- The use of the Certificates of Medical Necessity (CMNs) for motorized wheelchairs, manual wheelchairs and power operated vehicles will be phased out for claims with Dates of Service (DOS) on or after May 5, 2005

- For claims with Dates of Service before May 5, 2005, claims shall be submitted and processed using the fully completed and signed CMNs (CMS-843 for motorized wheelchairs, CMS-844 for manual wheelchairs, CMS-850 for power operated vehicles, and CMS-854 Section C Continuation Form).

- Until system changes are fully implemented in April 2006, suppliers shall submit a partially-completed unsigned CMN. Contractors shall not edit on these partially-completed CMNs.

- Since MMA §302 allows physicians, physician assistants nurse practitioners, or clinical nurse specialists to prescribe power mobility devices, it is no longer necessary to require a specialist in physical medicine, orthopedic surgery, neurology or rheumatology to provide a prescription for POVs.

- The physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) must conduct a face-to-face examination of the beneficiary and write a prescription for the PMD.

- The written prescription must include the beneficiary's name; the date of the face-to-face examination; the diagnoses and conditions that the PMD is expected to modify; a description of the item; the length of need; the physician or treating practitioner's signature; and the date the prescription is written.

- The written prescription for the PMD must be in writing and signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) who performed the face-to-face examination.The face-to-face examination requirement does not apply when only accessories for power mobility devices are being ordered.

- The physician or treating practitioner must submit a written prescription for the PMD to the supplier. This written prescription for the PMD must be received by the supplier within 30 days after the face-to-face examination. For those instances of a recently hospitalized beneficiary, the written prescription must be received by the supplier within 30 days after the date of discharge from the hospital.

Prior to dispensing a PMD, the DME supplier must obtain from the physician or treating practitioner who performed the face-to-face examination the written prescription accompanied by supporting documentation of the beneficiary's need for the PMD in the home. Pertinent parts from the documentation of the beneficiary's PMD evaluation may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans. The physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medically necessity for the PMD. The parts of the medical record selected should be sufficient to delineate the history of events that led to the request for the PMD; identify the mobility deficits to be corrected by the PMD; and document that other treatments do not obviate the need for the PMD, that the beneficiary lives in an environment that supports the use of the PMD and that the beneficiary or caregiver is capable of operating the PMD. In most cases, the information recorded at the face-to-face examination will be sufficient. However, there may be some cases where the physician or treating practitioner has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In this instance, those previous notes would also be needed. The physician, treating practitioner or supplier that is a HIPAA covered entity should make sure to remove or edit any materials that may be contained within the medical record that are not necessary to support the prescription. For example, a gynecologic report would not be needed in the records submitted for a beneficiary whose clinical need for a PMD is based solely on disability secondary to a stroke.

- As defined in chapter 3, of the Program Integrity Manual (PIM), if data analysis indicates potentially aberrant billing, contractors shall continue to follow the guidance as defined in this chapter when performing medical review on claims with dates of service on or after May 5, 2005

NEW/REVISED MATERIAL –
EFFECTIVE DATE*: May 5, 2005
IMPLEMENTATION DATE: October 17, 2005 (non-system changes)
April 3, 2006 (system changes)

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	5/Table of Contents
N	5/5.8/Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005/FY 2006 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-08	Transmittal: 121	Date:September 14, 2005	Change Request 3952

SUBJECT: Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims

I. GENERAL INFORMATION

A. Background*:* Section 302 (a) (2) (E) (iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sets forth revised conditions for Medicare payment of Power Mobility Devices (PMDs). This section of the MMA sets forth that payment for motorized or power wheelchairs may not be made unless a physician (as defined in section 1861(r)(1) of the Act), a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has conducted a face-to-face examination of the beneficiary and written a prescription for the PMD.

B. Policy: The use of the Certificates of Medical Necessity (CMNs) for motorized wheelchairs, manual wheelchairs and power operated vehicles will be phased out for claims with Dates of Service (DOS) on or after May 5, 2005.
For claims with Dates of Service before May 5, 2005, claims shall be submitted and processed using the fully completed and signed CMNs (CMS-843 for motorized wheelchairs, CMS-844 for manual wheelchairs, CMS-850 for power operated vehicles, and CMS-854 Section C Continuation Form).

Until system changes are fully implemented in April 2006, suppliers shall submit a partially - completed unsigned CMN. Contractors shall not edit on these partially completed CMNs**.**

Since MMA §302 allows physicians, physician assistants, nurse practitioners, or clinical nurse specialists to prescribe power mobility devices, it is no longer necessary to require a specialist in physical medicine, orthopedic surgery, neurology or rheumatology to provide a written prescription for POVs.

The physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) must conduct a face-to-face examination of the beneficiary and write a prescription for the PMD.

The written prescription for the PMD must include the beneficiary's name; the date of the face-to-face examination; the diagnoses and conditions that the PMD is expected to modify; a description of the item; the length of need; the physician or treating practitioner's signature; and the date the prescription is written.

The written prescription for the PMD must be in writing and signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner or clinical

nurse specialist) who performed the face-to-face examination. The face-to-face examination requirement does not apply when only accessories for power mobility devices are being ordered.

The physician or treating practitioner must submit a written prescription for the PMD to the supplier. This written prescription for the PMD must be received by the supplier within 30 days after the face-to-face examination. For those instances of a recently hospitalized beneficiary, the written prescription must be received by the supplier within 30 days after the date of discharge from the hospital.

Prior to dispensing a PMD, the DME supplier must obtain from the physician or treating practitioner who performed the face-to-face examination the written prescription accompanied by supporting documentation of the beneficiary's need for the PMD in the home. Pertinent parts from the documentation of the beneficiary's PMD evaluation may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans. The physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medically necessity for the PMD. The parts of the medical record selected should be sufficient to delineate the history of events that led to the request for the PMD; identify the mobility deficits to be corrected by the PMD; and document that other treatments do not obviate the need for the PMD, that the beneficiary lives in an environment that supports the use of the PMD and that the beneficiary or caregiver is capable of operating the PMD. In most cases, the information recorded at the face-to-face examination will be sufficient. However, there may be some cases where the physician or treating practitioner has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In this instance, those previous notes would also be needed. The physician, treating practitioner or supplier that is a HIPAA covered entity should make sure to remove or edit any materials that may be contained within the medical record that are not necessary to support the prescription. For example, a gynecologic report would not be needed in the records submitted for a beneficiary whose clinical need for a PMD is based solely on disability secondary to a stroke.

As defined in chapter 3, of the Program Integrity Manual (PIM), if data analysis indicates potentially aberrant billing, contractors shall continue to follow the guidance as defined in this chapter when performing medical review on claims with dates of service on or after May 5, 2005.

II. BUSINESS REQUIREMENTS

***"Shall"* denotes a mandatory requirement**
***"Should"* denotes an optional requirement**

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3952.1	Contractors shall allow payment for a reasonable and necessary power mobility device when a face-to-face examination of the beneficiary has occurred by a physician, a physician assistant, a nurse practitioner, or clinical nurse specialist and a written prescription was supplied. DMERCs and shared systems shall not edit for the date of the face to face examination.				X					
3952.2	Contractors and shared systems shall continue to require the fully completed and signed certificates of medical necessity (CMNs) for motorized wheelchairs, manual wheelchair and power-operated vehicles (POVs) for claims with date of service (DOS) before May 5, 2005.				X			X		
3952.3	Contractors and shared systems shall cease applying logic related to the existing certificates of medical necessity (CMNs) for motorized wheelchairs, manual wheelchairs and power operated vehicles (POVs) for claims with dates of service (DOS) ON OR AFTER May 5, 2005.				X			X		
3952.4	For claims with dates of service (DOS) on or after May 5, 2005, contractors and shared systems shall no longer require signed certificates of medical necessity (CMNs) for motorized wheelchairs, manual wheelchairs and power operated vehicles (POVs) when processing claims with any of the following wheelchair base HCPCS codes: E1050-E1060; E1070-E1224; E1229- E1295; K0001-K0007; K0009-K0012; K0014.				X			X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3952.5	For claims with dates of service (DOS) on or after May 5, 2005, CWF shall no longer require signed certificates of medical necessity (CMN) for motorized wheelchairs, manual wheelchairs, and power operated vehicles. CWF will no longer monitor CWF Category 59 for claims with the following wheelchair base HCPCS code: E1050-E1060; E1070-E1224; E1229- E1295; K0001-K0007; K0009-K0012; K0014. (**TO BE IMPLEMENTED 4/2006)**								X	
3952.6	For claims with dates of service (DOS) on or after May 5, 2005, contractors and shared systems shall no longer require a signed certificate of medical necessity (CMN) when processing claims with any of the following wheelchair accessory HCPCS code: E0973; E0983-E0984; E0990; E1226; K0016-K0018; K0020; K0046-K0047; K0053; K0195.				X			X		
3952.7	For claims with dates of service (DOS) on or after May 5, 2005, CWF shall no longer require signed certificates of medical necessity (CMN) when processing claims with any of the following wheelchair accessory HCPCS codes: E0973; E0983-E0984; E0990; E1226; K0016-K0018; K0020; K0046-K0047; K0053; K0195. (**TO BE IMPLEMENTED 4/2006)**								X	
3952.8	Until system changes are fully implemented in April 2006, contractors shall allow suppliers to submit partially - completed unsigned CMNs.				X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3952.9	Contractors and shared systems shall not edit on any information contained on the partially - completed unsigned CMNs.				X			X	X	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3952.10	Contractors shall provide very specific guidance to providers and suppliers on how to properly document and submit claims in the absence of the motorized wheelchair, manual wheelchair and power operated vehicle (POV) certificates of medical necessity (CMNs) with dates of service (DOS) on or after May 5, 2005.				X					
3952.11	Contractors shall provide very specific guidance to suppliers on how to properly document and submit claims using the existing certificates of medical necessity (CMNs) for motorized wheelchairs, manual wheelchairs and power operated vehicles (POVs) during the transition period, so that claims can continue to be processed while system changes are being made.				X					
3952.12	Until system changes are fully implemented in April 2006, contractors shall provide very specific guidance to providers and suppliers on how to partially-complete the unsigned CMN with dates of service (DOS) on or after May 5,				X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	2005**.**									
3952.13	A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly				X					
3952.14	Contractors shall update all supplier manuals, bulletins, articles, and other educational documents to reflect the new changes contained in this CR.				X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date *: May 5, 2005 **Implementation Date:** **For non-system changes: October 17, 2005** For system changes: April 3, 2006 **Pre-Implementation Contact(s):** For non-system changes: Camille Soondar, 410-786-9370 Camille.soondar@cms.hhs.gov For system changes: Joanne Spalding, 410-786-3352 Joanne.spalding@cms.hhs.gov **Post-Implementation Contacts:** For non-system changes: Camille Soondar, 410-786-9370 Camille.soondar@cms.hhs.gov For system changes: Joanne Spalding, 410-786-3352 Joanne.spalding@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005/ FY 2006 operating budgets.**

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Medicare Program Integrity Manual

Chapter 5 – Items and Services Having Special DME Review Considerations

Table of Contents
(Rev. 121, 09-14-05)

5.8 - *Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims*

(Rev.121, Issued: 09-14-05, Effective: 05-05-05, Implementation: 10-17-05 (non-system changes)/ 04-03-06 (system changes)

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